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PRELIMINARY DISCUSSION OF THE

PERFORMANCE MEASUREMENT DESIGN

FOR THE CALIFORNIA MENTAL HEALTH SERVICES ACT (MHSA)

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For several decades, the mental health system has been involved in defining and refining performance indicators. Potential performance indicators are numerous, and the system is involved both in current measurement activities, and in developing better ways to measure indicators such as access, service quality, fidelity to practice guidelines, cultural competency, cost effectiveness, client outcomes, perception of care, and more. The California mental health system is guided by performance visions, goals and benchmarks in current regulation, (e.g., Realignment, Children's System of Care, Integrated Services for Homeless Mentally Ill, Older Adult System of Care, Mentally Ill Offender Crime Reduction Grant Program, etc.) and recovery-based system transformational agendas (e.g., President's New Freedom Commission on Mental Health). These represent core and global performance areas for the mental health system, and are a point of departure for developing accountability indicators specific to the Mental Health Service Act (MHSA). The performance indicators and measurement methods of the AB2034 program in particular have been successful in evaluating the program and demonstrating the effectiveness of services/supports with regard to client outcomes. The MHSA performance measurement design will use the enrollment and tracking concepts of the AB2034 program to assess client outcomes, while appreciating the need to measure broader, accountability indicators of systems of care, and prevention/early intervention aspects of the mental health system pertinent to the MHSA. Performance with respect to the MHSA will be measured on three levels, (1) the individual client level, (2) the mental health program/system accountability level, and (3) the public/community-impact level. (Please see attached performance measurement diagram, Attachment 1.) Building upon previous stakeholder processes and experience with measurement and program monitoring/oversight, the performance measurement strategies listed below will be undertaken. It is important to note that the process of designing and implementing appropriate performance measurement is itself part of the MHSA transformational agenda. Therefore evaluation and modification of strategies are expected over time, in order to ensure their consistency with the recovery-based philosophy and the transformational intent of the MHSA.

Individual Client Level Information
(Child/Adolescent, Adult and Older Adult Community Integrated Service and Supports)

1. Client and Services/Supports Tracking

Clients and the services they receive must be tracked throughout the mental health system. Indicators of interest may include access, new services/ programs/ supports pertinent to the MHSA, evidence-based practices, process between various levels or intensity of services, and/or disengagement from mental health services/supports. Client and services/supports data capture is envisioned to be achieved through

interoperable information systems residing at both the state and local levels. A phased-in approach will be used to achieve this long-term goal of full interoperability. In the early phase, current local/county information systems or new county-purchased systems (with electronic mental health record capabilities) will be used in conjunction with a DMH-developed statewide system that captures key client process/outcome events and other performance information. It is believed that some counties (with vendors) may choose to incorporate the capture of new information into their own systems, so standards and specifications will be provided. In general, numerous and creative options for county/provider data collection, reporting, and systems interoperability are being studied for feasibility in order to provide counties with the greatest possible flexibility with regard to reporting MHSA and other data, (e.g. Federal Data Infrastructure Grant supported Uniform Reporting System requirements).

2. Client Outcomes

Each fully served MHSA client will need to receive an initial, baseline assessment, in addition to ongoing outcomes assessments, the frequency and type of which will be determined by a stakeholder process, and may be differentially based on the level of care, type of service(s)/supports received, and client needs/service goals. This longitudinal design for outcomes data capture is preferred over other methodologies (e.g., point-in-time) because it allows comparisons to be made between initial and subsequent assessments, thereby providing information on client change that may be associated with mental health system services and supports.

The MHSA has highlighted the successes of the AB2034 program, including its ability to measure successful changes for individuals over time. In order to capture individual client changes, several points in time must be compared. For the most part, the client surveys currently required by DMH have a somewhat different format, which lends itself to a point in time assessment approach. The current surveys provide an evaluation of services by clients/caregivers and the "outcome" sections have an imbedded comparison structure wherein outcome statements are prefaced by the phrase: " As a result of the services I received…." In contrast to this type of comparison anchoring, MHSA outcomes will include the capture of events and circumstances for which a baseline and subsequent assessments are necessary. For example, for the MHSA, number of days homeless in a specified time frame prior to services/supports will need to be compared to the number of days homeless in an appropriate comparison time frame. The viability of this design is supported by the AB2034 program's success. This design is also likely to be acceptable for the MHSA due to its low client to personal service coordinator ratios and emphasis on planning and budgeting for success and accountability.

Some data will be captured through client/family self-report on perception surveys, while other data will be obtained through service staff, client/family, and (in some cases) collateral service/agency collaboration, and entered by service providers/staff. State and local information systems interoperability, based on statewide standards, will be the mechanism by which this client outcome information is captured (as described in the immediately preceding section). DMH will work with counties/providers to provide flexible system options with regard to measurement of outcome indicators. (Please see Attachment 3 for an initial information technology conceptualization/vision for interoperability of systems that track individual client, services and outcome information. More information on this vision will be available and posted on the DMH MHSA website soon.)

DMH and stakeholders will be considering the client outcome concepts in light of system transformational processes that emphasize recovery and resilience philosophies. To be consistent with that transformational agenda, some of the more traditional outcome indicators (e.g., symptoms) are likely to be updated, and more recovery concepts (e.g., hopefulness, personal empowerment, wellness) will be added.

Previous stakeholder processes have identified a number of client outcome indicators of particular value for measurement of mental health system performance. A consolidation analysis of necessary and/or desirable client outcomes stipulated in legislation/regulation (i.e., Realignment, Children's System of Care, Integrated Services for Homeless Mentally Ill, Older Adult System of Care, Mentally Ill Offender Crime Reduction Grant Program) (as well as associated documents referenced in legislation) revealed indicators centered around the core concepts. (Please see Attachment 2, which documents this consolidation analysis.) Recovery and resilience indicators, and the core concepts from legislation (listed below) will become the foundation for the development of specific client outcome indicators for the MHSA.

Client Outcome Indicator Concepts:

Recovery / resilience based indicators:

e.g. Hopefulness
Wellness
Empowerment
Self-Efficacy
Etc.

Positive outcomes should also be achieved with respect to:

Housing
Criminal justice system involvement
Employment/education

Hospitalization (acute/long term restrictive levels of care)
Income/entitlements
Family preservation
Symptoms/suffering
Suicide
Functioning
Substance Use
Quality of life
Illness self-management
Social/community connectedness
Individualized service plan goals
Physical health
Etc.

The State Department of Mental Health will seek input from stakeholders (e.g., providers, clients/families, measurement experts, administrators, etc) in the effort to arrive at meaningful and measurable MHSA outcome indicators. The above list does not necessarily reflect what the ensuing stakeholder process will provide. Rather, it shows a consolidation of results from previous stakeholder processes and input aimed at establishing concepts for mental health client outcome evaluation. The above list also represents "high level" concepts that encompass outcomes for child/adolescent, adult and older adult community integrated services and supports[1]. Guided by the stakeholder process, the State Department of Mental Health will determine what specific indicators and measurement strategies will best address these concepts for specific age groups, programs, client goals, etc. (Please see final section of this paper for more information regarding the stakeholder process and plans for a Performance Measurement Committee).

Individual, client-level data, (both client/services/supports tracking and client outcome data) will also be interfaced with billing/claiming data to determine cost-effectiveness of system services/supports delivery.

Mental Health Program/System Accountability Level

Program and system performance are best measured through monitoring and oversight activities. Program/system accountability indicators would include indicators of cultural competency, recovery promotion, fidelity to evidence-based practices, budget guidelines and comprehensive, inter-disciplinary, inter-agency, coordinated service delivery models, to name a few. Monitoring, quality improvement projects and oversight processes at the local/county and state levels

[1] Considerable overlap with respect to these client outcome indicator concepts exists between mental heath regulation/legislation and the California Outcome Measurement System (CalOMS) for Alcohol and Drug Programs. Please see attached table of client outcome indicator concepts.

will ensure that mental health system activities are consistent with the MHSA goals and intent.

This oversight and monitoring will be achieved through stakeholder processes that include clients/family members at both local and State levels. Client satisfaction and evaluation results from surveys, focus groups, etc. are part of this program/system accountability level of performance measurement. Similarly, provider and staff evaluation/satisfaction with regard to the mental health system (e.g., perceived effectiveness of the structure of the system, inter-agency issues, service models, etc.) are important for mental health system evaluation.

DMH will work with stakeholders (e.g., providers, counties, oversight bodies including clients/family members) in establishing appropriate performance indicators, monitoring criteria and evaluation designs. DMH will further provide guidance, technical assistance, and will develop interoperable means for information capture and accountability reporting where feasible.

Public/Community-Impact Level

The previous two levels of performance indicator measurement involve MHSA client tracking and fidelity/process monitoring of programs/systems. Three types of information are applicable to the public or community impact level.

One type is the large-scale information that is available through large data systems/projects or other agencies. Population prevalence of mental illness, community mental health need, and percent of youth in juvenile justice placements are examples of large-scale indicators. Although local mental health programs probably cannot demonstrate an impact on these large, social indicators in the short run, the vision for a transformed, integrated system of service delivery and supports would certainly include broad, community impact. Although indicators of this type are difficult to interpret with respect to determining the relative contributions of the mental health system versus other agency/system and environmental factors to the outcome, they provide a statement of the status of communities with respect to met and unmet need.

The second type of performance information is data (typically counts) relevant to community-type services provided through the mental health system (and sometimes with collaborative agencies or organizations). These include outreach services, for example, to homeless mentally ill individuals, emergency response team services, prevention efforts, community mental health screenings (early intervention), educational seminars, media and anti-stigma campaigns, etc. This type of data is typically not tied to an individual receiving services and being tracked within a services and supports system. Data on these types of activities, both in terms of process and number of persons served or reached help to measure the mental health system's impact on those who have not as yet sought mental health services or have not been engaged by the mental health system.

Data on these types of activities also help to track the mental health system's efforts to enhance the general public's mental health awareness and understanding.

The third type of performance information is gathered through external agency / community organization surveys, responses from the public, county boards of supervisors, and others, on the impact of programs, prevention efforts, etc. For example, community satisfaction surveys, interviews with elected officials, and examination of media reports can all provide information on the impact that mental health programs/strategies are having on the public and communities.

Guided by a stakeholder process, the State Department of Mental Health will determine the performance indicators and measurement methods relevant to examining the public/community impact of MHSA services, supports and system transformational processes. Performance indicators are likely to be specific to particular efforts, and special evaluation studies may be needed that are tailored to such strategies as they are developed and implemented.

Performance Measurement Levels and Data Methods / Sources

It is important to maintain the distinction between performance measurement levels (i.e., Individual Client Level, Mental Health System Accountability Level, and Public / Community Impact Level) and the means / methods of measuring or acquiring data to address a particular indicator or concept. For example, although a particular indicator / concept may reside within the system accountability level, it may be best measured through individual client self-report. At the same time, client reported perception with respect to a particular aspect of the system, such as access to services, is not a client outcome; rather, it is an evaluation of the system's process, capacity, quality, etc. from the client's point of view. In general, performance at the three levels may be measured in a number of different ways, with different data sources.

Stakeholder Process and Plans for a Performance Measurement Committee

Stakeholder Process:

DMH will be having stakeholder conference calls and workgroups to disseminate information on performance measurement, as well as to receive input and comments from stakeholders on the process of high-level measurement conceptualization and indicator development. The first of these conference calls and workgroups are scheduled for April 26, 2005 and May 4, 2005, respectively. Please see the DMH MHSA Website for more information on these meetings, as well as future conference calls and meetings with respect to performance measurement.

Performance Measurement Committee:

In order to guide the performance measurement process, performance indicator selection/development, and measurement methods, DMH plans to develop a Performance Measurement Committee. That committee will be a working committee that will have the responsibility of determining the cross walk between current measurement strategies / processes and new, transformational MHSA measurement approaches. The committee will be responsible for recommending indicators, their measurement, and recommending the universe of data collection requirements for the MHSA. The committee will also consider the end product of the performance measurement process as it identifies and recommends performance indicators. A clear picture of the usefulness of the indicators for particular audiences will be provided, including such uses as policy development, decision support, quality improvement, administration, management, etc. More information on the structure, process of nomination and timelines for the establishment and work products of the committee will be available shortly. Please check the DMH MHSA Website for future postings regarding the Performance Measurement Committee.

PERFORMANCE MEASUREMENT

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PUBLIC / COMMUNITY- IMPACT LEVEL

(Evaluation of Global Impacts and Community-Focused Strategies)

- **Mental Health Promotion and Awareness**
- **Mental Health System Structure / Capacity in Community**
- **Community Reaction / Evaluation / Satisfaction with regard to mental health system**
- **Large-Scale Community Indicators**

MENTAL HEALTH SYSTEM ACCOUNTABILITY LEVEL

(Evaluation of Community Integrated Services and Supports – *Program/System-Based Measurement*)

- **Monitoring / Quality Assurance / Oversight** *(multi-stakeholder process)*
- **Client / Family Satisfaction / Evaluation of Services and Supports**
- **Staff / Provider Evaluation / Satisfaction with regard to mental health system**

INDIVIDUAL CLIENT LEVEL

(Evaluation of Community Integrated Services and Supports – *Individual Client Tracking*)

- **Client and Services Tracking**
- **Individual Client Outcomes Tracking**

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PERFORMANCE MEASUREMENT

INDIVIDUAL CLIENT LEVEL

(Evaluation of Community Integrated Services and Supports – *Individual Client Tracking*)

Client and Services Tracking *(Examples)*

•Client-specific information, e.g., contact, demographic information, reason for system disengagement, etc.
•Services / supports information, e.g., new services/programs/supports pertinent to the MHSA, evidence-based practices, levels of care, partnering agency/provider services, etc.

(Client and services/supports data capture is envisioned to be achieved through interoperable information systems residing at both the state and local levels. A phased-in approach will be used to achieve this long-term goal of full interoperability.)

Individual Client Outcomes Tracking *(Examples)*

•Initial and periodic bio/psycho/social assessments
•Ongoing assessments of core outcomes. The following are examples:

Recovery & Resilience Oriented Client Outcome Indicators : (These are examples; indicators and measures to be determined through stakeholder and committee recommendations.)	Housing	Functioning
	Criminal justice system involvement	Substance Abuse
	Employment / Education	Quality of Life
	Hospitalization (acute//long term restrictive levels of care)	Illness self-management
Hopefulness	Income / Entitlements	Social / community connectedness
Wellness	Family preservation	Individual service plan goals
Empowerment	Symptoms / Suffering	Physical health
Self-efficacy, etc.	Suicide	Etc.

(State and local information systems interoperability, based on statewide standards, will be the mechanism by which this client outcome information is captured. DMH will work with counties/providers to provide flexible system options with regard to measurement of outcome indicators.)

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PERFORMANCE MEASUREMENT

MENTAL HEALTH SYSTEM ACCOUNTABILITY LEVEL

(Evaluation of Community Integrated Services and Supports – *Program/System-Based Measurement*)

Monitoring / Quality Assurance / Oversight *(multi-stakeholder process)* ***(Examples)***

Local / county plans and performance with respect to:

- Cultural competency / no disparities
- Recovery / Resilience philosophy and promotion
- Full participation of clients / family members in service delivery system processes
- Fidelity to evidence-based practice guidelines or model programs
- Adherence to budget / timelines
- Staff / provider competencies
- Adherence to appropriate client-to-staff ratios
- Quality (performance) improvement projects
- Service partnerships - Comprehensive / inter-agency / coordinated service delivery
- Supportive services (e.g., housing, employment, peer-delivered supportive services)
- Coordinated services for co-occurring disorders
- Costs, cost-effectiveness of services
- Etc.

(Measured with standardized review criteria, monitoring tools, electronic data entry / reporting interfaces, etc. Cost information to be associated with client, service, and outcomes tracking information to determine costs per client, cost-effectiveness and cost-benefit analyses of programs, etc.)

Client / Family Satisfaction / Evaluation of Services and Supports ***(Examples)***

- Mental Health Statistics Improvement Program (MHSIP) indicators and surveys
- Surveys / assessments targeting specific services / supports appraisal by clients / families / caregivers
- Focus groups / multiple means of eliciting client / family / caregiver input
- Etc.

Staff / Provider Evaluation / Satisfaction with regard to mental health system ***(Examples)***

- Perceived effectiveness of the structure of system, inter-agency issues, effectiveness of service models, etc.
  - Interviews / surveys/ focus groups
- Etc.

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PERFORMANCE MEASUREMENT

PUBLIC / COMMUNITY- IMPACT LEVEL

(Evaluation of Global Impacts and Community-Focused Strategies)

Mental Health Promotion and Awareness *(Examples)*

- Outreach services (e.g., homeless, rural communities, Tele-health, etc.)
- Community Emergency Response Team Services
- Community Mental Health / Depression Screenings
- Educational Seminars (e.g., general public, primary care settings, schools, etc.)
- Anti-Stigma and Anti-Discrimination Campaigns
- Prevention and Early Intervention Efforts
- Workforce Recruitment and Development (e.g., university, licensing board collaborations, continuing education)
- Community Support Groups
- Media, public awareness announcements, (e.g., Recovery & Resiliency)
- Access and educational enhancements (e.g., Network of Care website, promotion of recovery philosophy)
- Etc

(Typically measured by counts of individuals reached, screened, informed, etc.)

Mental Health System Structure / Capacity in Community *(Examples)*

- Inventory of available services & supports
- Location of services, including inter-agency, outreach, mobile, natural setting, etc (e.g., GIS mapping)
- Etc.

Community Reaction / Evaluation / Satisfaction with regard to mental health system *(Examples)*

- Media reviews
- Interviews with public officials
- Assessment of community members
- Etc.

Large-Scale Community Indicators *(Examples)*

- Population prevalence of mental illness
- Community mental health need / unmet need
- Percents of youth in juvenile justice or Level12-14 group home placements
- Etc.

INDIVIDUAL CLIENT OUTCOME INDICATOR CONCEPTS

Individual Client Outcome Indicator Concepts
Proposed in Legislation

	Data Source	Older Adult System of Care	Children's System of Care	AB2034	Realignment	MIOCRG[1]	MHSA
A) Housing*	PO	4d	4	1,7a,7b	1b		6
B) Criminal Justice System Involvement*	PO	4e	1,4	2,7h	1c	1	2
C) Employment / Education*	PO		2,4	3,7c,7e	1d		3,4
D) Hospitalization (acute/restrictive levels of care) *	CSI/PO		4	4			
E) Physical Health*	PO			5			
F) Income / Entitlements*	CSI/PO	4c		6,7f			
G) Suicide	CSI	1					1
H) Substance Abuse*	PO	4f		7j			
I) Symptoms / Suffering	PO	2		7i			5
J) Quality of Life	PO	5					
K) Functioning	PO	3,4b	3	7c			
L) Family Preservation*	PO			7b			7
M) Illness Self-Management*	PO			7g			
N) Social / Community Connectedness*	PO	4a		7d			
O) Individualized Service Plan Goals*	PO				1a		

* These indicators are also collected for the California Outcome Measurement System (CalOMS) project for Alcohol and Drug Programs.

[1] MIOCRG = Mentally Ill Offender Crime Reduction Grant (SB 1485) project collects numerous data elements not specified in legislation.

Older Adult System Of Care
(From California Mental Health Master Plan)

Reviewed: W&I Codes 5730-5734; 5689-5689.9; Master Plan from California Mental Health Planning Council

1. Prevent suicide

2. The proposed intervention will significantly diminish the impairment

3. The proposed intervention will prevent significant deterioration in an important area of life functioning

4. Establish a baseline for the following performance indicators for clients:

    a. Rate at which clients are actively engaged in some community support network as measured by participation in peer support or self-help groups, socialization center programs, or other activities

    b. Psychological impairment and functioning for clients in the target population

    c. Rate at which clients receive income support entitlements

    d. Rate at which clients remain in the least restrictive, most appropriate housing consistent with their capabilities for at least one year

    e. Rate at which clients spend time in local jails

    f. Rate at which clients w/a secondary diagnosis of substance abuse are abusing dangerous drugs, prescription drugs and over-the-counter medications

5. To establish or re-establish quality of life as defined by the older adult in partnership with his or her family and community natural support system

Children's System Of Care

Reviewed: W&I Codes 5850-5870; 5872; 5875-5878; 5879-5883

1. Enable juvenile offenders to decrease delinquent behavior (W&I 5851)

   ~A 20% reduction in out-of-county ordered placements of Juvenile Justice wards and social service dependents (W&I 5852.5)

   ~ To reduce the rate of recidivism incurred for wards in targeted juvenile justice programs

   ~A statistically significant reduction in the rate of recidivism (W&I 5852.5)

2. Enable special education pupils to attend public school & make academic progress (W&I 5851)

   ~Statistically significant improvement in school attendance and academic performance of seriously emotionally disturbed special education pupils treated in day treatment programs which are wholly or partially funded by applications for funding award moneys (W&I 5852.5)

   ~To increase school attendance for pupils in targeted programs

   ~To increase the grade level equivalent of pupils in targeted programs from admission to discharge

   ~ A 10% reduction in out-of-county nonpublic school residential placements of special education pupils (W&I 5852.5)

3. A method to show measurable improvement in individual and family functional status for children enrolled in the SOC (W&I 5865)

4. A method to measure and report cost avoidance and client outcomes for the target population which includes, but is not limited to, state hospital utilization, group home utilization, nonpublic school residential placement, school attendance and performance, and recidivism in the juvenile justice system (W&I 5865)

AB 2034

Reviewed: AB 2034

1. The number of persons served, and of those who are able to maintain housing
2. The number of persons with contacts with local law enforcement and the extent to which local and state incarceration has been reduced or avoided
3. The number of persons participating in employment service programs including competitive employment
4. The amount of hospitalization that has been reduced or avoided
5. Maintain the best possible physical health
6. The extent to which veterans identified through these programs' outreach are receiving federally funded veteran's services for which they are eligible
7. The individual personal services plan shall ensure that members of the target population involved in the system of care receive age, gender and culturally appropriate services, to the extent feasible, that are designed to enable recipients to:

    a) Live in the most independent, least restrictive housing feasible, in the local community

    b) For clients with children, to live in a supportive housing environment that strives for reunification with their children or assists clients in maintaining custody of their children as is appropriate

    c) Engage in the highest level of work or productive activity appropriate to their abilities and experience

    d) Create and maintain a support system consisting of friends, family, and participation in community activities

    e) Access an appropriate level of academic education or vocational training

    f) Obtain an adequate income

    g) Self-manage their illness and exert as much control as possible over both the day-to-day and long-term decisions which affect their lives

    h) Reduce or eliminate serious anti-social or criminal behavior and thereby reduce or eliminate their contact with the criminal justice system

    i) Reduce or eliminate the distress caused by the symptoms of mental illness

    j) Have freedom from dangerous addictive substances

Realignment
Part 2: The Bronzan-McCorquodale Act

Reviewed: W&I Codes 5600-5772.5

1. The committee should consider outcome measures in the following areas (**§ 5612**):

    a) Treatment plan goals met
    b) Stabilization of living arrangements
    c) Reduction of law enforcement involvement and jail bookings
    d) Increase in employment or education activities

SB 1485 Mentally Ill Offender Crime Reduction Grants (MIOCRG)

Reviewed: Penal Code 6045-6046

1. Reduce crime and offenses committed by mentally ill offenders
   Data dictionary:
   http://www.bdcorr.ca.gov/cppd/miocrg/miocrg2000/rfp_toolkit/miocrg_cde.pdf

Mental Health Services Act
Individual Client Outcomes

Reviewed: Sections 1 - 19

1. Reduce suicide
2. Reduce incarcerations
3. Reduce school failure/dropout
4. Reduce unemployment
5. Reduce prolonged suffering
6. Reduce homelessness
7. Reduce removal of children from their homes

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INFORMATION TECHNOLOGY CONCEPTUALIZATION FOR MENTAL HEALTH SERVICES ACT PERFORMANCE OUTCOMES MEASUREMENT

Attachment 3

Individual Client, Services and Outcomes Tracking

Reasonably Static Data Elements for Client and Service Information Tracking

Systems with electronic mental health record (EMHR) capabilities would replace current County systems that capture and report out CSI and MediCal data to DMH/DHS.

New systems would be capable of tracking individual client services ongoing, reporting CSI data elements & MediCal claiming/HIPAA transactions. Would track additional data elements that address services pertinent to the MHSA, (e.g., EBPs), and improve tracking of client process between levels/types of care, and disengagement from the system, if appropriate.

New systems would be capable of inter-operability and smoothly interfacing with external client assessment and outcomes reporting modules that accept additional information at the time of service record data entry (and/or at other appropriate times)

Assessment and outcome records to be connected to service record information by specific triggers, e.g. time/date stamp of service, service type, client characteristics, etc.

INTEROPERABILITY

Flexible/Changeable Data Elements

Data capture envisioned to be achieved through interoperable information systems residing at both the state and local levels. A phased-in approach to be used to achieve long-term goal of full interoperability. In the early phase, current local/county information systems or new county-purchased systems (with electronic mental health record capabilities) will be used in conjunction with a DMH-developed statewide system that captures key client process/outcome events and other performance information. Some counties (with vendors) may choose to incorporate the capture of new information into their own systems, so standards and specifications will be provided. In general, numerous and creative options for county/provider data collection, reporting, and systems interoperability are being studied for feasibility in order to provide counties with the greatest possible flexibility with regard to reporting MHSA and other data, (e.g. Federal Data Infrastructure Grant supported Uniform Reporting System requirements).

Client & services tracking elements (County system extract) deposited into local database

Client outcomes tracking elements deposited into local database

Local Database

DMH programming "pulls" data from both tracking sources to DMH servers, or, alternatively, data remains distributed at county level and DMH programming acts on local servers for reporting. Data and reports are also "pushed" back to county. Pull & push process to be "real time" as records are entered, or, alternatively, at acceptable, timely intervals.